

CERTIFICATE OF DEATH

00708

00703

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Sykesville</i>		c. LENGTH OF STAY IN TB <i>14 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Sykesville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Old Fuddrill Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Franklin</i>		Middle <i>J. Anderson</i>		Last <i>Anderson</i>	
4. DATE OF DEATH Month <i>Jan.</i> Day <i>31</i> Year <i>1962</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 27, 1903</i>		9. AGE (In years last birthday) <i>58</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James M. Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Alice Ball</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Mrs Catherine Anderson - Sykesville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>573. Dehydration</i> DUE TO (b) <i>Excessive Vomiting Acidosis</i> DUE TO (c) <i>Spastic Colitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>One week</i> <i>One week</i> <i>20 years</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 30, 1962</i> to <i>Jan 31, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 30, 1962</i> , and that death occurred at <i>6:55 A.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Sani Okutman</i>		M.D.		22b. DATE <i>Feb. 1, 1962</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		22d. ADDRESS <i>Sykesville, Md.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-2-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony</i>	
23d. LOCATION (City, town or county) <i>Crookville, Howard Co. Md.</i>		23e. (State) <i>Md.</i>		23f. (Country) <i>U.S.A.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Julius A. Wright</i>		ADDRESS <i>Sykesville, Md.</i>		25a. RECEIVED BY REGISTRAR <i>Feb 5 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>		DATE <i>FEB 5 '62</i>		25c. (City or town) <i>Sykesville, Md.</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

20200

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8 & 9 Film G305 1/26/62 iwk

00709

CERTIFICATE OF DEATH

Reg. Dist. No.

00704

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. H.H. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LARK BROWN RJ. HOWARD				d. STREET ADDRESS 308 SHENANDOAH AVE. #25			
3. NAME OF DECEASED (Type or print) First ANTONINIA Middle BENCH Last (nee BARTOSKEWICZ)				4. DATE OF DEATH Month 1 Day 18 Year 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. (?) 1871	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 1 Days 18 Hours 18 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? LITHUANIA ✓				13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Joseph Bench, 1809 LANCASTER AVE. #31			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arterio-Sclerosis 450.0 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) Senility INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1st , 19 61 , to Jan. 18th , 19 62 , that I last saw the deceased alive on Jan. 18th , 19 62 , and that death occurred at 6 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank E. Shipley M.D.				ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED 1/20/62			
PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-22-62		22c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Sons Inc., Hollins & Poppleton				24a. REC'D BY REGISTRAR JAN 23 '62		24b. REGISTRAR'S SIGNATURE William S. Thomas	

CERTIFICATE OF DEATH

1920

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Blank form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00710

CERTIFICATE OF DEATH

Reg. Dist. No. 00705

1. PLACE OF DEATH a. COUNTY Howard County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b 90 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - #4 d. STREET ADDRESS 1723 Kennoway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DR. Lorenzo B. EVANS		4. DATE OF DEATH Month Jan. Day 24 Year 1962	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/12/1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor		10b. KIND OF BUSINESS OR INDUSTRY Medical	9. AGE (In years last birthday) 85
11. BIRTHPLACE (State or foreign country) Deep Valley, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Evans		14. MOTHER'S MAIDEN NAME Cinderella Ullom	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lorenzo B. Evans, Jr.		Address 1723 Kennoway Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease (c) 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 hrs 2 da 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 2 da 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-31 , 19 62 to 1-24 , 19 62 that I last saw the deceased alive on 1-23 , 19 62 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Herbert, M.D.		DATE SIGNED 1-25-62	
PHYSICIAN'S NAME (Type) Thomas F. Herbert		Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/27/62	22c. NAME OF CEMETERY OR CREMATORY Park Moreland Memorial Com.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		24a. REC'D BY REGISTRAR JAN 29 '62	
ADDRESS 4905 York Rd. Baltimore 12, Md.		24b. REGISTRAR'S SIGNATURE Arthur J. Krasner	

STANDARD BANK

01750



CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00706

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. LENGTH OF STAY IN TB <u>22 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>-</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Woodbine</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN WAUGH GLASCOCK</u>		d. STREET ADDRESS <u>Daisy Road</u>	
4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 21, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Riding School</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Glascock</u>		14. MOTHER'S MAIDEN NAME <u>ANDREA Waugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wife</u>	
17. INFORMANT Address <u>Wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420-1 DUE TO <u>Anterior & Extensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>10 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 mon.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u>		DATE SIGNED <u>Jan. 18, 1962</u>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-20-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Glenwood, Harford, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. & H. H. Hight</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 22 '62</u>	
ADDRESS <u>Wm. & H. H. Hight</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Examiner: _____

9. Signature of Coroner: _____

10. Signature of Medical Officer: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

00712

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. COUNTY Howard Elkridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5523 Race Rd.		d. STREET ADDRESS 5523 Race Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle GREEN Last		4. DATE OF DEATH Month Jan. Day 22 Year 1962	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1889
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkridge Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Moses Green		14. MOTHER'S MAIDEN NAME Ida Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT James Brown		Address 5523 Race Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 JAN , 19 62 , to 2 JAN , 19 62 , that I last saw the deceased alive on 2 JAN , 19 62 , and that death occurred at 4 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Groleau		ADDRESS (Street, city or town, state) 5608 Main St Elkridge 27 Md	
DATE SIGNED 4 Jan 62			
PHYSICIAN'S NAME (Type) George E. Groleau		5608 Main St Elkridge 27 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/1962	
22c. NAME OF CEMETERY OR CREMATORY Haines Cem.		22d. LOCATION (City, town or county) (State) Elkridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate Rhodians Schroeder		ADDRESS 322 N.	
24a. REC'D BY REGISTRAR JAN 8 '62		24b. REGISTRAR'S SIGNATURE Charles L. Kline	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1113 Montgomery Road				d. STREET ADDRESS 1113 Montgomery Road			
3. NAME OF DECEASED (Type or print) First Middle Last Thelma Louise Graham Harless				4. DATE OF DEATH Month Day Year January 23 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1915	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY New Way Market			
11. BIRTHPLACE (State or foreign country) W. V. West Virginia				12. CITIZEN OF WHAT COUNTRY? Yes U.S.A.			
13. FATHER'S NAME Thomas Graham				14. MOTHER'S MAIDEN NAME Ethel Masters			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No no				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Nellie Chapman				Address West Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-28-62			
22c. NAME OF CEMETERY OR CREMATORY Mablegrove Am.				22d. LOCATION (City, town, or country) (State) Fairmont West Virginia			
23. FUNERAL DIRECTOR Howard H. Hubbard 4187 Wilkins Ave				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
				DATE JAN 29 '62			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00714

Items 7, 13 & 14 Film G-506 2/5/62 iwk

00709

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shaffer's Convalescent Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1643 ABBOTTSON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Matilda Julia Hessler First Middle Last 4. DATE OF DEATH Jan. 24 1962 Month Day Year		5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/26/1878 Year 9. AGE (in years) (IF UNDER 1 YEAR) (IF UNDER 24 HRS.) yrs. Months Days Hours Min. 83		10a. USUAL OCCUPATION (Give kind of work done for most of year, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. PLACE, County, or foreign country MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME Pauline unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT MR. August Hessler-Elliott City Address 322 Rogers	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, rt. lower lobe. 490X Conditions, if any, which gave rise to immediate cause (b) (c) 5 da. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (1) (This hospital) attended the deceased from 6-19 1961 , to 1-24 1962 , that (1) (we) last saw the deceased alive on 1-23 1962 , and that death occurred at 1:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Herbert 22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D. 22d. ADDRESS Ellicott City, Maryland		22b. DATE SIGNED 1-24-62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL CREMATION 1-27-62 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 23d. LOCATION (City, town or county) (State) Baltimore Md		24. FUNERAL DIRECTOR'S SIGNATURE Lemuel J. Ruck ADDRESS 5305 Hayford Rd 25a. REC'D BY REGISTRAR JAN 29 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00716

00711

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 New Cut Road		d. STREET ADDRESS 19 New Cut Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLA Middle JOHNSON Last		4. DATE OF DEATH Month Jan. 14, Day 19 Year 62	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> (See) DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1887
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months 74 Days 19 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME John Cole		14. MOTHER'S MAIDEN NAME Lolly Cole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Violette Beverly 2805 W. Fayette Street	
17. INFORMANT Violette Beverly 2805 W. Fayette Street		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4-22X DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 10 YRS		INTERVAL BETWEEN ONSET AND DEATH 12 HRS	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 1-14 , 19 62 that (I) (we) last saw the deceased alive on 1-13 , 19 62 , and that death occurred on 8-28 AM, from the causes and on the date stated above.			
22a. SIGNATURE P. V. Thorpe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) PETER V. THORPE, MD		22d. ADDRESS 409 COLUMBIA RD, ELLICOTT CITY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/62	
23c. NAME OF CEMETERY OR CREMATORY Granit, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead 918 Druid Hill Ave. Balto.1, Md.		25a. REC'D BY REGISTRAR JAN 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00717

00712

1. PLACE OF DEATH a. COUNTY Howard County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Elkridge		c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Tip Top Motel, Elkridge, Maryland		d. STREET ADDRESS 1902 N. Collington Avenue	
3. NAME OF DECEASED (Type or print) CHARLES EDWIN JORDAN		4. DATE OF DEATH January 2, 1962	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 14, 1911
9. AGE (In years last birthday) 50 yrs.		10. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pump operator		10b. KIND OF BUSINESS OR INDUSTRY City Water Dept	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sherwood Jordan		14. MOTHER'S MAIDEN NAME Alice Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-7939	
17. INFORMANT Mrs Madeline Bittner		Address Baltimore 6 Md 5628 North Ave(Overlea)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive & Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Howard G. Shaub M.D. EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or county) _____ DATE SIGNED 1/2/62			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Jan 10, 1962	22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	22d. LOCATION (City, town, or country) (State) Overlea Baltimore Co Md
23. FUNERAL DIRECTOR J. Melville Jenkins		24a. REC'D BY REGISTRAR 2713 KIRK AVE	
24b. REGISTRAR'S SIGNATURE C. L. Jenkins		DATE JAN 10 '62	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you. NO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

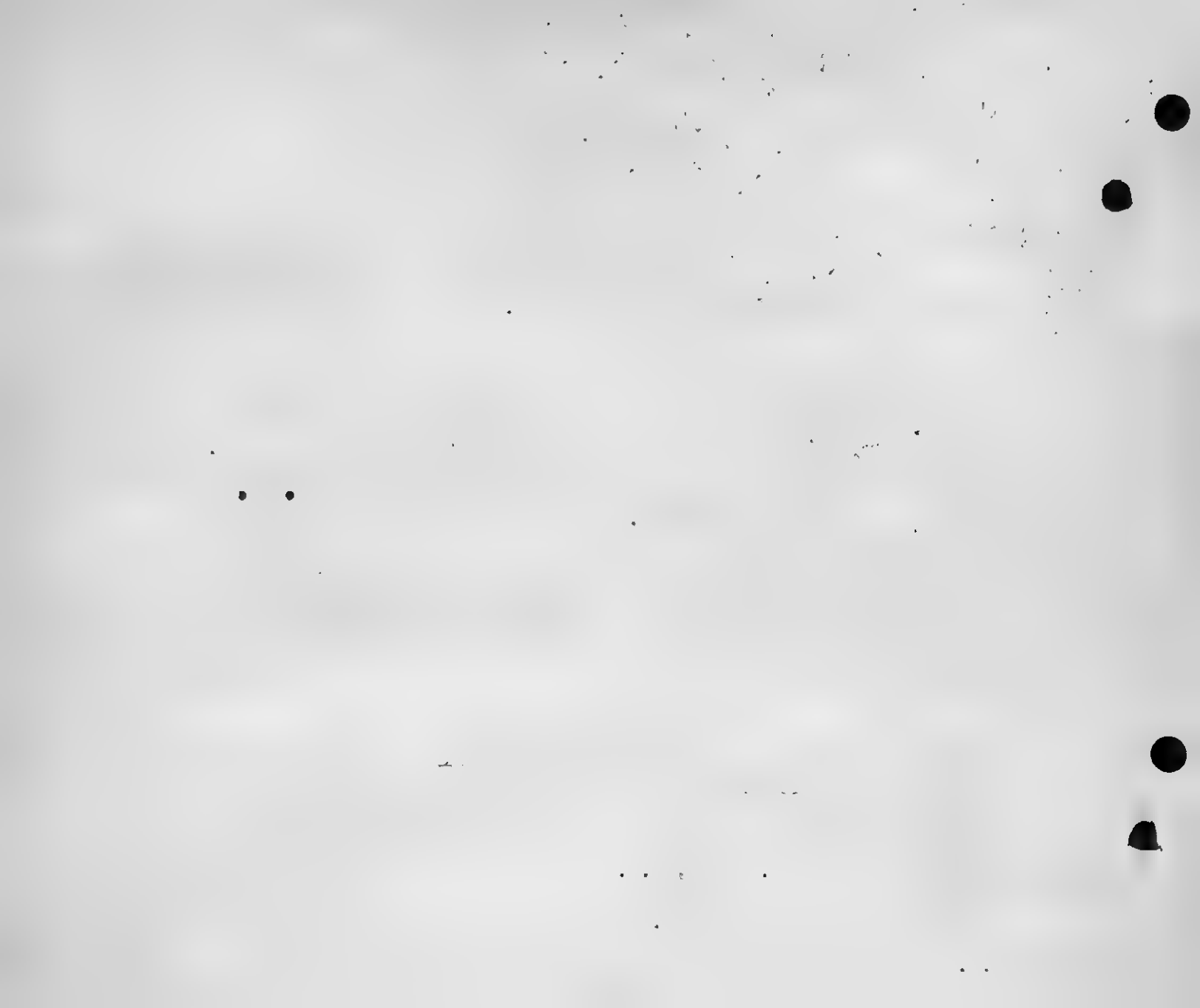
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00718

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Duvall Road</u>				d. STREET ADDRESS <u>Duvall Road</u>			
3. NAME OF DECEASED (Type or print) <u>ELLA MAY JUNKINS</u>				4. DATE OF DEATH <u>January 17 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 22, 1915</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Woodbine, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bruce Junkins</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Catherine Junkins, Duvall Rd. Woodbine, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic and Hypertensive Cardiovascular Disease.</u> Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (c) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY <u>19</u>		20d. INJURY OCCURRED <u>Partial</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Petty</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-20-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>				22d. LOCATION (City, town, or country) (State) <u>Sunshine, Md</u>			
23. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>				24a. REC'D BY REGISTRAR <u>JAN 22 1962</u>			
				24b. REGISTRAR'S SIGNATURE <u>John L. Hume</u>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13. STATE OF MARYLAND
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HOWARD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MARRIOTTSTVILLE c. LENGTH OF STAY IN It MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HENRYTOWN ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville d. STREET ADDRESS Henrytown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) G. ORGE ALEXANDER KING		4. DATE OF DEATH Month 1 Day 21 Year 1962		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 18, 1910		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 1 Days 21		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Ind.				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John A. King				14. MOTHER'S MAIDEN NAME Alice Sands				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.II				16. SOCIAL SECURITY NO. Mr. Alma Johnson - 5 Jones Ave., Catonsville, Md.				17. INFORMANT Mr. Alma Johnson - 5 Jones Ave., Catonsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1-22-62			
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.				Address (Street, city, town, or county) Baltimore National				22b. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or country) (State) Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22c. DATE THEREOF 1-24-62				23. FUNERAL DIRECTOR Arthur H. Haight				24. REC'D BY REGISTRAR Arthur S. Hanna				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00720

Item 14 Film G305 1/10/62 iwk

00715

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Frederick Rd.		d. STREET ADDRESS 11 E. Hartha St.	
3. NAME OF DECEASED (Type or print) GRACE E. KIRBY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/20/87	
9. AGE (In years last birthday) 75 yrs.		10. UNDER 1 YEAR Months Days 3 19	
11. UNDER 24 HRS. Hours Min. 62		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Moody		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 54X DUE TO Cardiac failure, Aneurysm, dissection (b) Carcinoma of rectum & metastasis (c) Generalized PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 1959 to 1962	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to 1962, that (I) (we) last saw the deceased alive on 3 Jan 1962, and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Howard E. Hall		22b. DATE SIGNED 3 Jan 62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Aylesville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town or county) Balto. 25, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Port Ave.		25a. REC'D BY REGISTRAR DATE JAN 5 '62	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00716

00721

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Behind 6714 Washington Blvd. in woods</u>		d. STREET ADDRESS <u>6714 Washington Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Roger F. Knight</u>		4. DATE OF DEATH <u>Jan. 22, 1962</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 24, 1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sr. Supervisor Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Jeremiah R. Knight</u>	
14. MOTHER'S MAIDEN NAME <u>Katie L. Snyder</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>218-26-5382</u>		17. INFORMANT <u>Lillian E. Knight, Elkridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation from hanging.</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>_____</u> (a), stating the underlying cause last. (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hung himself from a tree</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-22-1962</u> Hour a.m. <u>1:15</u> p.m. <u>_____</u>		20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>		20f. (City or town) <u>Elkridge</u> (County) <u>Howard</u> (State) <u>Md</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>George E. Burgtorf</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>George E. Burgtorf</u> M D		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or country) <u>Baltimore, Maryland</u> (State) <u>_____</u>	
23. FUNERAL DIRECTOR <u>Howard H. Hubbard 4107 Wilkens Avenue #29</u>		24a. REC'D BY REGISTRAR <u>JAN 24 '62</u>	
ADDRESS <u>_____</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

2

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

decade 4

TO HOSPITAL OR ATTENDING



CERTIFICATE OF DEATH

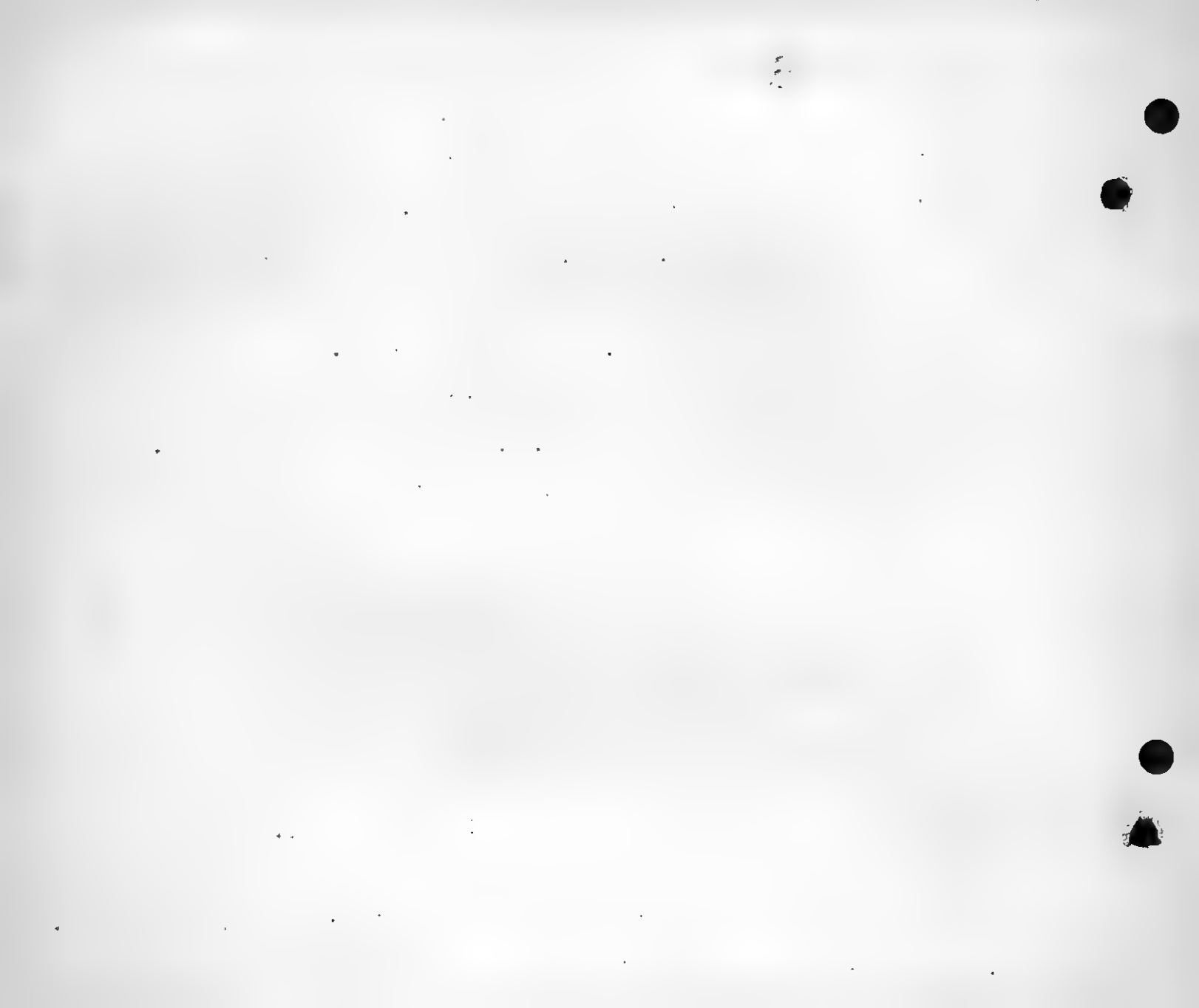
Reg. Dist. No.

00719

00724

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V-1-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer's Convalescent Retreat				d. STREET ADDRESS 124 Rose St.			
3. NAME OF DECEASED (Type or print) First CHARLES Middle M. Last REICHERT				4. DATE OF DEATH Month Jan. Day 14 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14 1901		9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Can co.		11. BIRTHPLACE (State or foreign country) Reading, Penna.	
13. FATHER'S NAME Joseph Reichert				14. MOTHER'S MAIDEN NAME Anna von Glahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ??			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HTASND DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 HR - 2 YRS -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9 , 1962, to 1-14 , 1962, that I last saw the deceased alive on 1-12 , 1962, and that death occurred at 12:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Peter J. Higinbotham				M.D. Ellicott City, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/62		22c. NAME OF CEMETERY OR CREMATORY Laureldale		22d. LOCATION (City, town, or county) (State) Muhlenburg Twp Berks Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR JAN 17 '62		24b. REGISTRAR'S SIGNATURE John E. Higinbotham	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that the attending physician or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3 & 4 Film G306 2/2/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

00720

00725

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. LENGTH OF STAY IN 1b <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHAFER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER RUBY</u>				4. DATE OF DEATH Month Day Year <u>JAN 7, 1962</u> 19			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u> <u>JULY 26, 1884</u> 75 yrs.	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.A.R.A.</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Stu</u> <u>CLARA S. STRAIP</u>		Address <u>833 UNION AVE.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> DUE TO <u>Cardiac Failure</u> DUE TO <u>Arterio-sclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>48 hrs</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1962</u> to <u>Jan 7, 1962</u> , that I last saw the deceased alive on <u>Jan 6, 1962</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1/9/62</u> DATE SIGNED ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D. <u>46 Church Road, Ellicott City, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 10, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chomsky</u>				ADDRESS <u>3617 Chestnut Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thorne</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

00721

00726

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shafer's Convalescent Retreat				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDNA SHIPLEY				4. DATE OF DEATH Jan 26, 1962 Month Jan Day 26 Year 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 10, 1893	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) A. Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Nitzel				14. MOTHER'S MAIDEN NAME Anita Patchi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, colon, metastatic 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27 , 19 61 , to 1-26 , 19 62 , that I last saw the deceased alive on 1-26 , 19 62 , and that death occurred at 9:30 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert, M.D.				ADDRESS (Street, city or town, state) 46 Church Road, Ellicott City, Md			
DATE SIGNED 1-26-62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-62		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JAN 29 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL: ATTENTION: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00727

CERTIFICATE OF DEATH

Reg. Dist. No.

00722

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellicott City		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat		d. STREET ADDRESS Bethany Lane					
3. NAME OF DECEASED (Type or print) First Middle Last JAMES F. SINGHASS		4. DATE OF DEATH Month Day Year Jan. 11, 1962 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian J. Singhass		14. MOTHER'S MAIDEN NAME Iena Stump					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 215-32-2224		INFORMANT Mrs. Phillip German, Bethany Lane, Ellicott City		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure.</u> 1777X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Prostate Gland.</u> DUE TO 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> , 19 <u>58</u> to <u>Jan 11</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan 8</u> , 19 <u>62</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>		DATE SIGNED <u>1/14/62</u>			
ACTUAL SIGNATURE <u>William F. Lassaway</u>		M.D. <u>Ellicott City, Md.</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-1962		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Randallstown, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 15 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00728 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00723

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clarksville</u> c. LENGTH OF STAY IN b. <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clarksville</u> d. STREET ADDRESS <u>Cedar Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Edward Page</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 17, 1888</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Elec. Appliance</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Tribble</u>						14. MOTHER'S MAIDEN NAME <u>Nannie Page</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> W.W. I						16. SOCIAL SECURITY NO. <u>m 047-07-8303</u>						17. INFORMANT <u>Charles P. Taylor, Clarksville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3-1X</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Charles S. Whitaker</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles S. Whitaker, M.D.</u>				DATE SIGNED <u>1/16/62</u>				Address (Street, city, town, or county) <u>Clarksville, Md.</u>					
22a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION <u>Interment</u>				22b. DATE THEREOF <u>1/17/1962</u>				22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR <u>Loring Byers</u>				ADDRESS <u>8728 Liberty Rd.</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Conrad L. Thoms</u>	
VS. A15ME				SM 7/59				DATE <u>1/18/62</u>					

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00730
00725
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey</u> c. LENGTH OF STAY IN It <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harvey</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvey</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John C.</u> Middle <u>Walsh</u> Last <u>Walsh</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>guard</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Coast Guard</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Washington Indiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nichols J. Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Jane Kinsella</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-12-0323</u>		17. INFORMANT <u>Thos Virginia Harman Harvey Md</u> Address <u>529 Camp Meade Road, Luthien</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <u>Arteriosclerotic Cerebro vascular disease</u> DUE TO <u>422.1</u> (c) <u>Arteriosclerotic Cerebro vascular disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1962</u> to <u>January 1, 1962</u> that (I) (we) last saw the deceased alive on <u>January 1, 1962</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Roderick Shipley</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-1-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley</u>				22d. ADDRESS <u>529 Camp Meade Road, Luthien</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/3/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Headawedge</u>		23d. LOCATION (City, town or county) (State) <u>Mont Park Harvey Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Donaldson</u>				ADDRESS <u>Harvey Md</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 5 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>Chas E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be buried by the hospital or attending physician, the law requires that the death certificate be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00726

00731

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Long Corner				c. LENGTH OF STAY IN 1b Rural- Long Corner			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 3, Mt. Airy				d. STREET ADDRESS RFD 3, Mt. Airy			
3. NAME OF DECEASED (Type or print) Edgar - Warfield				4. DATE OF DEATH Month Jan. Day 1 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1901	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer and farmer				10b. KIND OF BUSINESS OR INDUSTRY Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter H. Warfield				14. MOTHER'S MAIDEN NAME Frances Mary Day			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-12-6263		17. INFORMANT Mrs. Lucy V. Warfield, Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 241X DUE TO Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 6 years 15 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/10 1958 to 1/11 1962 that (I) (we) last saw the deceased alive on 12/30 1961 , and that death occurred at 1:10P 1962 , from the causes and on the date stated above.							
22a. SIGNATURE James P. Kerr				22b. DATE SIGNED 1/3/62			
22c. PHYSICIAN'S NAME (Type) James P. Kerr				22d. ADDRESS Damascus, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1962		23c. NAME OF CEMETERY OR CREMATORY Prospect		23d. LOCATION (City, town or county) (State) Nr. Mt. Airy, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John L. Wolsmith				25a. REC'D BY REGISTRAR JAN 4 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 9/60

